Inside OUT

The newsletter of the CDC/HRSA Corrections Demonstration Projects
Produced four times a year through the collabortion of the
Correctional Technical Assistance and Training Project of SEATEC and the National Minority AIDS Council

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In this issue:

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Boston's Span, Inc.

by Gene Borden and Lynn Levy, Span Inc.

The Tip Staff at Span, Inc.: Gene Borden, Linda Mazak, Carol Walsh-Bolstad, Regina Dixon, and Osvaldo Riviera

Being featured in this month's newsletter is a great opportunity to let everyone know what our organization is all about. Span, located in Boston, is a private, non-profit agency established in 1976 by Lyn Levy, our Executive Director. We are the premier agency in New England offering services to the incarcerated population.

We provide services to offenders making the difficult transition from prison to community living. Our clients are offenders and ex-offenders only. To date we have served over 9,000 people who have been in prison. We specialize in the unique issues and needs of people who have been incarcerated and are looking to build healthy lives free of criminal behavior, substance abuse and incarceration.

Our services have evolved to maximize and support empowerment, recovery, health and independence. Programs are available to any eligible client who is: within six months of release, on parole from prison and coming back to the Boston area, wrapped up, in a pre-release center, in a halfway house or in a treatment center.

We have numerous programs to guarantee a complete array of options and services to fit the needs of all of our clients. Our programs include: release planning and preparation services; health and prevention education including subjects like HIV, STD, TB & HCV; outpatient substance abuse assessment and counseling, the reintegration support program (RSP) which provides short term transitional housing assistance, case management and substance abuse services; the Horizon Drop In Center, featuring planned events, social activities, meals, peer support, voice mailboxes and computer and internet access; the Transitional Intervention Project (TIP) and case management for our HIV+ clients. Included in this program are indi-

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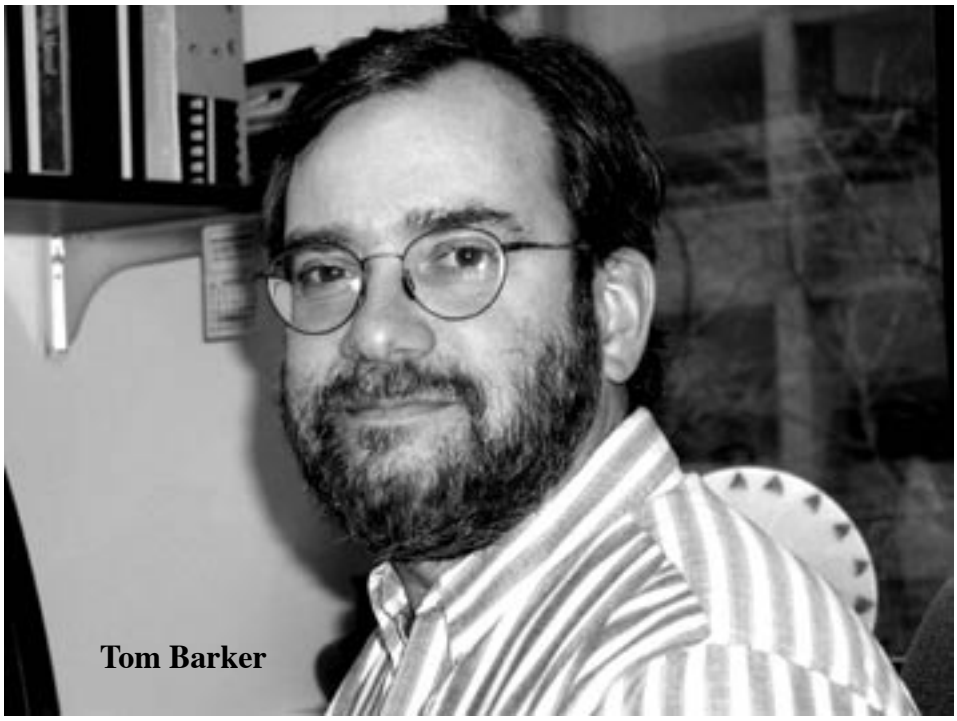
Tom Barker, MPH

by Johnetta Holcombe, MPH,
Corrections Technical Assitance & Training Project, Emory University


Tom Barker

As Project Director for the Corrections Demonstration Project (CDP) of the Massachusetts Department of Public Health (MDPH), Tom Barker oversees the administration of the CDPs by the community-based organizations, and serves as the liaison between the MDPH, CDC/HRSA, and the EPSC. In this role, Tom provides leadership in managing the success of "TIP," (The Transitional Intervention Project), which is the largest component of the CDP in the state. TIP is a statewide program that provides reintegration services to all HIV positive inmates in county houses of correction, state prisons and juvenile correctional facilities. Inmates enroll in the program, on average, three months prior to their release and remain TIP clients six to eight months in the community. Linkages to medical care, housing, mental health and substance abuse services comprise the core of TIP case manager efforts. Ultimately, TIP clients are linked to long-term case management and health services as they transition off the program. Approximately 1,100 inmates have enrolled in TIP.

Until recently, Tom also served as the project evaluator for the CDP initiatives in Massachusetts.

Tom's interest and passion for public health was fostered and nurtured through his educational and work experiences. He completed his graduate studies at the Boston University School of Public Health (BUSPH), where his degree concentration was in epidemiology and biostatistics. Upon completion of his graduate studies, Tom worked as a graduate assistant on a randomized trial comparing treatment options for problem-drinking workers at a large industrial site where he was responsible for conducting research interviews with the study participants. Additionally, he interviewed patients living with HIV at the Boston City Hospital Immunodeficiency Clinic for a study assessing help-seeking behaviors among this study population. His interview experiences — along with other aspects of his first public health job helped to put a human face to the sometimes distant aspect of the rigors of the epidemiologic process. He developed an enormous respect for the role that frontline research activity plays in ensuring the success of clinical and research trials; the vital role that frontline case managers and other key personnel play in ensuring the successful re-integration and provision of services to HIV positive inmates and ex-offenders; and further recognized the potential for successful integration of public health and community when the presence of the "human element" is consistent, effective and sincere. These lessons have been Tom's driving force. As he puts it, "I've been working in the HIV field ever since. Tough, but rewarding."

Tom's success as a public health practitioner/administrator/manager is certainly attributable to his formal education and training, but even more so from the collegial relationship that he has developed with, and the enormous respect that he has for the Massachusetts CDP frontline staff who directly serve clients. Tom meets monthly with the TIP case managers, who he describes as dedicated, passionate, and invaluable. In other words, without them, there would be no program to run. As a team, he and his colleagues meet to brainstorm difficult cases, and to review the successful ones. They continually network and collaborate with community providers and corrections staff outside of the MDPH, which enables them as a team to re-evaluate and adjust the Massachusetts case management/reintegration model to better serve clients. This, as Tom puts it, is the most rewarding aspect of what he does for the CDP.

Reward, however, does not come without challenge, and the biggest challenge that Tom sees in the work of the Massachusetts CDP, and indeed of the other six states, is: how do we oversee and propel projects that are new, creative, and with elements of innovativeness to meet the needs of an ever-changing/evolving epidemic and the people affected by it? There are no blueprints, and the (project) guidelines are constantly being created and re-created as each state finds what works and doesn't work for their respective clients, and the multi-faceted entities that serve the clients. This leads to a second, related challenge, which is the absolute necessity for consistent and effective communication, collaboration, and networking among the entities involved: CDC/HRSA, EPSC,

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CDC/HRSA Corrections Demonstration Project Grantee Meeting Agenda

Academy for Educational Development Washington, DC July 20 - 22, 2004

Goals:

1. Overview of the purpose of the Corrections Demonstration Project (CDP), other initiatives that have come about regarding HIV and corrections during the past five years, and future plans.
2. Summarize the activities conducted by the state grantees under the CDP in terms of:
   - What services were provided
   - Where services were provided
   - Corrections partners
   - Community partners
   - What needs were recognized and addressed
   - What changes occurred in the project design over the five-year period
3. Present findings from the projects:
   - Multi-site evaluation findings (both qualitative and quantitative data)
   - Local evaluation findings (both qualitative and quantitative data)
   - Cost analysis findings
   - Lessons learned

Tuesday July 20, 2004

11:30 A.M.–
1:00 P.M. **Lunch**

1:00–
1:15 P.M. **Welcome & Introductions**
Ronald Braithwaite, PhD Emory University/Evaluation & Program Support Center (EPSC)

1:15–
2:15 P.M. **Keynote Speaker**
CDC to identify

2:15–
3:15 P.M **Panel Discussion:**
Challenge with delivering DP/CCM for HIV-negative clients
Moderator: **Alyssa Robillard**, PhD Emory University/EPSC
• California • New Jersey

3:15–30 P.M. **Break**

3:30–
5:00 P.M. **Panel Discussion:**
Collaborating with prisons to deliver discharge planning/ community case management services.
Moderator: **Ted Hammett**, PhD Abt Associates, Inc/EPSC
• California • Florida
• Massachusetts • New Jersey

Wednesday July 21, 2004

8–9:00 A.M. **Continental Breakfast**

9:00–
10:30 A.M. **Panel Discussion: Finding appropriate housing for clients transitioning from jail to the community**
Moderator: **Sofia Kennedy**, MPH Abt Associates Inc/EPSC
• California • Florida
• Georgia • Chicago, IL

10:30–45 A.M. **Break**

10:45–
12:00 P.M. **Panel Discussion: Retaining clients in services after transitioning from jail to the community**
Moderator: Kimberly Jacob Arriola, PhD Emory University/EPSC
• Massachusetts • New Jersey
• New York

12–1:00 P.M. **Lunch on Your Own**

1:00–
1: 45 P.M. **Overview of Technical Assistance and Training for the CDP**
• Southeast AIDS Training and Education Center
• National Minority AIDS Council

1:45–
2:45 P.M. **Overview of Qualitative Evaluation Findings**
• **Alyssa Robillard**, PhD Emory University/EPSC
• **Tammy Woodring**, MPH Emory University/EPSC

2:45–3 P.M. **Break**

3:00–
4:00 P.M. **Panel Discussion: Overview of Cost Analysis Findings**
• **David Holtgrave**, PhD Emory University/EPSC
• **Desiree Hammond**, MPH Emory University/EPSC
• California • Georgia
• Illinois • Massachusetts

4:00–
5:00 P.M. **Overview of Quantitative Evaluation Findings**
• Sofia Kennedy, MPH Abt Associates Inc/EPSC

5:00–
5:30 P.M. **Final Thoughts from the Funders**
• Health Resources & Services Administration
• Centers for Disease Control & Prevention

Thursday July 22, 2004

External Guests are Welcome to Attend

8–9:00 A.M **Continental Breakfast**

8:00 A.M.–
12:00 P.M. **Poster Presentations by EPSC and State Grantees**
Representatives will be next to their posters and available for questions from 8:00–9:00 A.M. only.

9:00–
9:30 A.M. **Welcome & Introductions**
Ronald Braithwaite, PhD Emory University/Evaluation & Program Support Center (EPSC)

9:30–
10:30 A.M. **Panel Discussion: Overview of Corrections Demonstration Project: Findings & Lessons Learned**
Moderator: **Ted Hammett**, PhD Abt Associates Inc/EPSC
• Kimberly Jacob Arriola, PhD Emory University/EPSC
• California • Florida
• Georgia

10:30–45 A.M. **Break**

10:45 A.M.–
12:00 P.M. **Continuation of Panel Discussion**
• Chicago, IL • Massachusetts
• New Jersey • New York

12:00 **Adjourn**

Note to Panel Presenters:

- Panelists are asked to spend 10-15 minutes discussing how they have addressed the service delivery challenge identified by the moderator. They are not expected to prepare power point presentations in advance of the meeting. Someone will take notes online during the panel

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Imprisoned Youth at High Risk for Viral Hepatitis

by Holly R. Wilson, MHSE,CHES
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The estimated 106,000 adolescents and young adults in U.S. correctional facilities are at especially high risk for viral hepatitis. Compared with America's youth in the general public, these young people are more likely to use injection drugs and to practice unsafe sex than their peers. Both injection drug use and unsafe sex are well-known behaviors for getting viral hepatitis.

Juveniles with viral hepatitis who are released from correctional facilities can spread these viruses to other people if they continue their unsafe activities. Of all juvenile offenders, 50%-75% spend time later in adult correctional facilities. If these youth are not infected yet, they are at potential risk for hepatitis A, hepatitis B, and hepatitis C. Vaccination is the most effective means to prevent HAV and HBV infections.

CDC and its partners are exploring ways in corrections settings to help protect young people from getting viral hepatitis. Vaccination programs, health education projects, and prevention guidelines are at the heart of this effort.

Affordable Vaccines Available

Immunizing incarcerated youth helps to slow the spread of hepatitis A and hepatitis B both inside and outside institutional walls. Yet vaccines can be expensive and are often unavailable to some correctional institutions.

The Vaccines for Children (VFC) Program can help solve the cost problem. The VFC program, which includes both hepatitis A and hepatitis B vaccines, provides vaccines free of charge to eligible children through aged 18 years. Check out the VFC Web site (www.cdc.gov/nip/vfc) for specifics.

Vaccine Schedules

Hepatitis A Vaccine

Recommended dosages of HAVRIX®*				
Vaccinee's age (yrs)	**Dose (EL.U.)†**	**Volume (mL)**	**# doses**	**Schedule (mos)‡**
2-18	720	0.5	2	0,6-12
>18	1,440	1.0	2	0,6-12

* Hepatitis A vaccine, inactivated, GlaxoSmithKline.
† ELISA units.
‡ 0 months represents timing of the initial dose; subsequent numbers represent months after the initial dose.

Recommended dosages of VAQTA®*				
Vaccinee's age (yrs)	Dose (U.) †	Volume (mL)	# Doses	Schedule (mos) ‡
2-18	25	0.5	2	0,6-18
>18	50	1.0	2	0,6-12

* Hepatitis A vaccine, inactivated, Merck & Co., Inc.
† Units.
‡ 0 months represents timing of the initial dose; subsequent numbers represent months after the initial dose.

Hepatitis A vaccination is recommended for the following groups:

- Travelers to areas with increased rates of hepatitis A
- Men who have sex with men
- Injecting and non-injecting illegal drug users
- Persons with clotting-factor disorders (e.g., hemophilia)
- Persons with chronic liver disease
- Children living in regions of the U.S. with increased rates of hepatitis A during the baseline period of 1987-1997

Hepatitis B Vaccine

Recommended dosages and schedule for Eugerix B®*				
Vaccinee's age (yrs)	Dose (mcg.)	Volume (mL)	# Doses	Schedule (mos)†
1-19	10	0.5	3	0, 1-2, 4-6
20 and up	20	1.0	3	0,1,6

* Recombinant hepatitis B vaccine, manufactured by GlaxoSmithKline
† 0 months represents timing of the initial dose; subsequent numbers represent months after the initial dose.

Recommended dosages and schedule for Recombivax HB®				
Vaccinee's age (yrs)	Dose (mcg.)	Volume (mL)	# Doses	Schedule (mos)†
1-19‡	5	0.5	3	0, 1-2, 4-6
20 and up	10	1.0	3	0,1,6

* Recombinant hepatitis B vaccine, manufactured by Merck & Co., Inc.
† 0 months represents timing of the initial dose; subsequent numbers represent months after the initial dose.
‡ Children aged 11 - 15 years old, may be given Recombivax(r) on a two-dose 0, 4-6 months schedule using a 10mcg dose.

Hepatitis B vaccine is recommended for all children and adolescents aged 0-18 years and for persons in the following risk groups:

- Persons with multiple sex partners or recent diagnosis of a sexually transmitted disease
- Men who have sex with men
- Sex contacts of HBV-infected persons
- Injection drug users
- Household contacts of chronically infected persons
- Infants born to HBV-infected mothers
- Infants/children of immigrants from areas with high rates of HBV infection
- Health care and public safety workers who have exposure to blood in the workplace
- Chronic hemodialysis patients
- Inmates of correctional facilities
- Travelers working or living longer than 6 months in areas with high rates of HBV infection

Twinrix(r): Combined Hepatitis A and Hepatitis B Vaccine

Twinrix(r) is a combined hepatitis A and hepatitis B vaccine approved by the Food and Drug Administration for persons > 18 years old. Primary immunization consists of three doses, given on a 0-, 1-, and 6-month schedule, the same schedule as that used for single antigen hepatitis B vaccine. This means that a person can be fully vaccinated against both hepatitis A and hepatitis B with three injections compared to the five shots needed to complete the series using the single antigen formulations. Minimum time to complete the hepatitis A and hepatitis B series is the same (see table).

Twinrix(r) is indicated for immunization of persons 18 years of age or older against hepatitis A and hepatitis B. Any person in this age group having an indication for both hepatitis A and hepatitis B vaccination can be administered Twinrix(r), including patients with chronic liver disease, users of illicit injectable drugs, men who have sex with men, and persons with clotting factor disorders who receive therapeutic blood products. For international travel, hepatitis A vaccine is recommended for travelers to areas of high or intermediate hepatitis A endemicity; hepatitis B vaccine is recommended for travelers to areas of high or intermediate hepatitis B endemicity who plan to stay for 6 months and have frequent close contact with the local population.

Recommended Dosages and Schedules for Twinrix®				
Vaccine	Dosage		# Doses	Schedule (mos.)
	Hepatitis A Vaccine	Hepatitis B Vaccine		
Twinrix®	720 EL.U. *	20 mcg.	3	0,1,6

* ELISA Units

CDC/HRSA Corrections Demonstration Project *Grantee Meeting Agenda*

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presentations to generate a document outlining major challenges & solutions that the grantees faced during the CDP.
- The moderator will strictly adhere to the 15 minute time limit for each panelist.

Panelists will be asked to discuss:

- Brief background on the project as needed
- How the project addressed the challenge
- What the project would have done differently

The EPSC is requesting:

- Names from each grantee of who will sit on each panel
- A one-page overview of each intervention being discussed during a panel (guidance is forthcoming).

Note regarding poster presentations:

- Representatives will be asked to stand next to their posters from 8:00 - 9:00 am on Friday July 22.
- Each poster is expected to provide an overview of each intervention within the project.

Meeting Participants:

* CDC/HRSA/EPSC
* Project Director, CBO representative, Evaluator, & upper level public health officials
* Special Guests (on Friday only) - National/local organizations that may be interested (grantees & funders to generate list & submit to EPSC). EPSC has sent invitations to these individuals.

For more information contact:
Keisha Marsh, 404-691-6868

5th Annual Centerforce Summit September 11-15, 2004

Models for Change: Delivering Successful Programs To Those Affected by Incarceration

Summit Pre-Course for Clinicians September 11-12, 2004 (CMEs Available) **General Summit** September 13-15, 2004	**Goal of the Summit:** To promote discussions between consumers and their families, corrections, public health, and service providers. Topics include best practices of prevention, transitional, and on-going services prior to and upon release from custody.
Conference Location: San Francisco Airport Marriott 1800 Old Bayshore Highway Burlingame, CA. 94010 Phone 650.692.9861 www.marriotthotels.com/sfobg ***15 Miles from Downtown San Francisco***	**Featured Tracks:** • Fathers Behind Bars (Co-Sponsored by Family Corrections Network) • Children & Family Services • Transitional Services • Prevention & Education • Restorative Justice • Correctional Demonstration Project (Co-Sponsored by Centers for Disease Control and Prevention)

More Information

Beth Houghton, *Summit Chair*
415.456.9980 ext. 124
bhoughton@centerforce.org

Jacqueline Tulsky, M.D., *Pre-Summit*
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Or visit website:
www.centerforce.org/summit

For Registration Materials:
Please contact RDL Enterprises
Ph: 916.443.0218
Karl@RDLent.com *or visit*
www.rdlent.com

Span Inc.

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vidual case management, referrals, housing assistance and aftercare support and follow up, Transitional Housing (THP) and Housing Search for HIV+ clients from transitional to permanent housing, the Community Resource Center (CRC) which includes employment assistance, literacy and GED education, programs for violence reduction, relapse prevention, life skills and more.

Of course, the fabric that holds our agency together and makes us so successful is our staff. We are fortunate to have a dedicated group of unique and talented employees who routinely go the extra mile for each of our clients. This recipe for success assures each individual that they will receive the best and most complete services that any agency can offer. We are more than proud of the work that we do. Hopefully, our continuing enrichment and enhancement projects, that all staff take part in, will result in even more services and activities for our clients in the future.

Centerforce's 4th Annual Summit 2003

"New Directions for Integrating Services for the Incarcerated and their Families"

Mick Gardner and Beth Houghton

Centerforce's Annual Summit 2003, October 18-22, was the most successful yet. With over 300 participants, the five-day event (including the inaugural 2-day Pre-Summit for Clinicians) was a forum for education, networking and important discussions for service providers, public health professionals, custody and correctional healthcare staff, former inmates and their families.

Edward Latessa, Ph.D., noted criminologist and professor of Criminal Justice at the University of Cincinnati provided the dynamic keynote address, "What Works in Correctional Intervention."

All plenary sessions, as well as workshops were well received, imparting knowledge as well as inspiration to all working with the incarcerated and their families.

For the first year, the Centerforce Inside Out Summit presented two annual awards. Jeannie Woodford, former warden to San Quentin State Prison and present Director of the California Department of Corrections received the 1st Annual Jeannie Woodford Award, in recognition of outstanding leadership in proactive correctional community collaboration. And the 1st Annual Harold Atkins Award went to Harold Atkins, Centerforce Board member and former prisoner, in recognition of successfully breaking the cycle of incarceration.

Join us this year for the 5th Annual Centerforce Summit, September 11-15, 2004 at the San Francisco Airport Marriott in Burlingame, California.

See you at the Summit!

Tom Barker

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Health Departments, CBOs and correctional facilities. Indeed, reward does not come without challenge, and challenge has its rewards - especially when we see programs like Massachusetts' TIP, which as Tom says, has made incredible strides in successfully reintegrating clients back into the community.

Although TIP's overall reintegration process seems to be moving forward, as in the case with other state CDPs, it is not without its challenges. Multiple diagnosed clients (i.e., HIV, substance abuse, and/or mental health) are often hard to place by virtue of the preponderance of issues they face and the services they need to become active, functioning citizens in the outside world. To that, add the stigma of being "formerly incarcerated," and sometimes homelessness; and suddenly clients become "ineligible" for certain services, especially housing, yet they are often the most in need. So, the cycle continues. It is no surprise, then, that in Massachusetts, housing emerges as the single most challenging service domain for meeting the needs of the clients. To the credit of Tom and the TIP staff, their case managers have done an incredible job finding creative housing resources.

For example, a client recently released from jail was about to lose her Section 8 Apartment temporarily for non-payment. TIP staff met her at a pizza joint to do an intake for a transitional housing placement for multiple-diagnosed clients. She completed her stay at the transitional placement, and through donations from a church and other local organizations was able to pay the money owed to reclaim her Section 8. Her daughter attended a summer camp supported by a local furniture company. The furniture company, upon hearing about the situation, donated furniture for the client's apartment. The client has been out of treatment for a year and remains clean and sober in her own apartment with her daughter. TIP case managers worked behind the scenes throughout this entire process. Sadly, however, some clients continue to fall through the cracks when the system fails them, despite the hard work and dedication of the front liners. Yet for Tom, the CDP work and the dedicated staff that work with him has provided the most interesting and challenging work of his public health career.

Tom, is not, however all work and no play! He is quite multi-faceted and multi-talented. He is an avid NY Yankees fan. Go figure, in Boston? He has a cultural/artistic side that allows him to write and publish children's stories and poetry. In fact, he plans to continue writing and will dedicate more time to it in the future. He is a busy father of three teenagers and as he puts it, "runs a free taxi service," for his children and their friends year round. It's a wonder Tom has time to do anything else! Look forward to seeing Tom's name in print — Tom Barker: Children's Author!

Good luck Tom, and many thanks to you and your staff for all that you do for the clients in Massachusetts!

July 11–12, 2004
Mental Health in Corrections: Improving Treatment to Change Lives. Paris Hotel, Las Vegas, NV. National Commission on Correctional Health Care (NCCHC), Academy of Correctional Health Care Professionals, and American Psychological Association. NCCHC, P. O. Box 1117, Chicago IL 60611, 773-880-1460, FAX 773-880-2424, www.ncchc.org.

July 31–Aug 5, 2004.
American Correctional Association Summer Conference. Chicago, IL. American Correctional Association (ACA), www.aca.org.

August 23–26, 2004
Ryan White CARE Act Grantee Conference. Marriott Wardman Park Hotel, Washington, DC. Registration 800-676-3391. General information: Paul Beasley 301-443-6562. www.psava.com/rwca2004.

Save The Date!

September 11–15, 2004
5th Annual Centerforce Summit. San Francisco Airport Marriott, Burlingame CA. www.centerforce.org/summit

November 13–17, 2004
National Conference on Correctional Health Care. Hyatt Regency, New Orleans, LA. National Commission on Correctional Health Care (NCCHC) and Academy of Correctional Health Care Professionals. NCCHC, P. O. Box 1117, Chicago IL 60611, 773-880-1460, FAX 773-880-2424, www.ncchc.org.

October 21–24, 2004
United States Conference on AIDS 2004 (USCA). Philadelphia, PA. National Minority AIDS Council (NMAC), 202-483-6622. www.nmac.org.

December 9–12, 2004
North American AIDS Treatment Action Forum (NATAF). Renaissance Grand Hotel, St. Louis, MO. Registration deadline Nov. 19, 2004. National Minority AIDS Council (NMAC), 202-483-6622. www.nmac.org.

January 8–12, 2005.
American Correctional Association Winter Conference. Phoenix, AZ. American Correctional Association (ACA), www.aca.org.

Planning for Seamless Transitions for Corrections Demonstrations Project Clients

Sarah K. Galllinelli, Corrections Initiative Coordinator, AIDS Coalition of Southern New Jersey, Bellmawr, NJ

As the correctional demonstration project comes to an end, there are many things to consider that will help ensure a smooth transition as your agency leaves the correctional institution. Planning for the end of the project can be one of the most challenging obstacles each project must address. Four years of navigating the system for HIV+ inmates has lead us to careful planning to ensure that the efforts and progress made by each correctional demonstration project continue after the project ends in September 2004.

Transition efforts should be carefully coordinated with other community based organizations and corrections staff to ensure a continued seamless transition into the community for the target population. Here are some suggestions to prevent gaps in service from occurring once the project ends.

- As soon as possible, inform clients of the exact date the project will end. Offer support and continue to navigate the system for clients that will be released within three months after the end of the project. Whenever possible, make initial referral contacts with community based organizations and provide each client with a general list of service providers that may be able to assist them post-release.
- Make individual checklists for each client on what they can do to ensure a smooth transition into the community. The checklist may include who and how to receive appropriate referrals for essential medical, care and support services and what each client should bring to their first appointments (i.e. list of medications, recent lab work, diagnosis, etc.)
- Make sure clients know how to ask for their medical records from the medical department. Provide them with a list of HIV service providers and services offered in the communities they plan to reside in after they are released.
- Coordinate a meeting with all social service, mental health, medical and substance abuse treatment staff at the correctional institution. Plan and prevent active clients from falling through the cracks. Obtain consent to discuss individual cases with each team of providers. Set up separate team meetings consisting of the client, social service staff, case manager, medical care provider, and if applicable, mental health staff to discuss pre and post release needs as identified by the correctional demonstration project in individual discharge planning and case management sessions.
- Create a directory of contact information and resource guide for the correctional institution that your project makes referrals to the most.
- Share an example of a comprehensive discharge plan for an HIV+ inmate with the other department heads within the institution that now will be responsible for care and discharge planning needs. Discuss with corrections staff barriers to care, how to navigate the disconnected system effectively, and share any lessons learned.
- Contact community based organizations that receive referrals regularly from your program staff working on the demonstration project and inform them of the new contact person from the institution that may be making referrals after the correctional demonstration project ends.
- Help other departments within the correctional institution coordinate and continue the already established programs by your project. Programs may include one or more of the following: Peer education, HE/RR classes, and support groups. Share effective curriculum and teaching strategies that will help each department continue to reach and educate the target population on HIV/AIDS.

Have any other ideas? Share them with us! E-mail them to **Sarah K. Gallinelli** at Sarah_Gallinelli@ACSNJ.org or call her at (856)-225-0118.